Group Code	Code	Description	Start	Modified	End
PR	1	Deductible Amount	1/1/95		
PR	2	Coinsurance Amount	1/1/95		
PR	3	Co-payment Amount	1/1/95		
OA	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	1/1/95		
OA	5	The procedure code/bill type is inconsistent with the place of service.	1/1/95		
OA	6	The procedure/revenue code is inconsistent with the patient's age.	1/1/95	6/30/02	
OA	7	The procedure/revenue code is inconsistent with the patient's gender.	1/1/95	6/30/02	
OA	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	1/1/95	6/30/02	
OA	9	The diagnosis is inconsistent with the patient's age.	1/1/95		
OA	10	The diagnosis is inconsistent with the patient's gender.	1/1/95	2/29/00	
OA	11	The diagnosis is inconsistent with the procedure.	1/1/95		
OA	12	The diagnosis is inconsistent with the provider type.	1/1/95		
OA	13	The date of death precedes the date of service.	1/1/95		
OA	14	The date of birth follows the date of service.	1/1/95		
CO	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	1/1/95	2/28/01	
OA	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	1/1/95	6/30/06	
PI	17	Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	1/1/95	6/30/06	
OA	18	Duplicate claim/service.	1/1/95		
OA	19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	1/1/95		
OA	20	Claim denied because this injury/illness is covered by the liability carrier.	1/1/95		
OA	21	Claim denied because this injury/illness is the liability of the no-fault carrier.	1/1/95		
CO	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	1/1/95	2/28/01	
PI	23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	1/1/95	6/30/05	
CO	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	1/1/95	6/30/00	
PR	25	Payment denied. Your Stop loss deductible has not been met.	1/1/95		
PR	26	Expenses incurred prior to coverage.	1/1/95		
PR	27	Expenses incurred after coverage terminated.	1/1/95		
CO	29	The time limit for filing has expired.	1/1/95		
PR	31	Claim denied as patient cannot be identified as our insured.	1/1/95		
PR	32	Our records indicate that this dependent is not an eligible dependent as defined.	1/1/95		
PR	33	Claim denied. Insured has no dependent coverage.	1/1/95		
PR	34	Claim denied. Insured has no coverage for newborns.	1/1/95		
PR	35	Lifetime benefit maximum has been reached.	1/1/95	10/31/02	
CO	38	Services not provided or authorized by designated (network/primary care) providers.	1/1/95	6/30/03	
CO	39	Services denied at the time authorization/pre-certification was requested.	1/1/95		
OA	40	Charges do not meet qualifications for emergent/urgent care.	1/1/95		
OA	44	Prompt-pay discount.	1/1/95		
CO	45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	1/1/95	10/31/06	
CO	49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/95		
CO	50	These are non-covered services because this is not deemed a `medical necessity' by the payer.	1/1/95		
CO	51	These are non-covered services because this is a pre-existing condition	1/1/95		

OA	53	Services by an immediate relative or a member of the same household are not covered.	1/1/95		
CO	54	Multiple physicians/assistants are not covered in this case .	1/1/95		
CO	55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	1/1/95		
CO	56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.	1/1/95		
CO	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	1/1/95	2/28/01	
OA	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	1/1/95	2/28/07	
CO	60	Charges for outpatient services with this proximity to inpatient services are not covered.	1/1/95		
OA	61	Charges adjusted as penalty for failure to obtain second surgical opinion.	1/1/95	6/30/00	
CO	66	Blood Deductible.	1/1/95		
CO	69	Day outlier amount.	1/1/95		
CO	70	Cost outlier - Adjustment to compensate for additional costs.	1/1/95	6/30/01	
OA	74	Indirect Medical Education Adjustment.	1/1/95		
OA	75	Direct Medical Education Adjustment.	1/1/95		
CO	76	Disproportionate Share Adjustment.	1/1/95		
CO	78	Non-Covered days/Room charge adjustment.	1/1/95		
PR	85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR)	1/1/95	7/9/07	
OA	87	Transfer amount.	1/1/95		
CO	89	Professional fees removed from charges.	1/1/95		
OA	90	Ingredient cost adjustment.	1/1/95		
CO	91	Dispensing fee adjustment.	1/1/95		
CO	94	Processed in Excess of charges.	1/1/95		
OA	95	Benefits adjusted. Plan procedures not followed.	1/1/95	6/30/00	
CO	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	1/1/95	6/30/06	
PI	97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	1/1/95	10/31/06	
OA	100	Payment made to patient/insured/responsible party.	1/1/95		
CO	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	1/1/95	2/28/99	
CO	102	Major Medical Adjustment.	1/1/95		
CO	103	Provider promotional discount (e.g., Senior citizen discount).	1/1/95	6/30/01	
OA	104	Managed care withholding.	1/1/95		
OA	105	Tax withholding.	1/1/95		
OA	106	Patient payment option/election not in effect.	1/1/95		
CO	107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.	1/1/95	10/31/06	
PI	108	Payment adjusted because rent/purchase guidelines were not met.	1/1/95	6/30/02	
OA	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/95		
CO	110	Billing date predates service date.	1/1/95		
CO	111	Not covered unless the provider accepts assignment.	1/1/95		
PI	112	Payment adjusted as not furnished directly to the patient and/or not documented.	1/1/95	2/28/01	
CO	114	Procedure/product not approved by the Food and Drug Administration.	1/1/95		
PI	115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	1/1/95	7/9/07	
OA	116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.	1/1/95	2/28/01	
CO	117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	1/1/95	2/28/01	
OA	118	Charges reduced for ESRD network support.	1/1/95		
CO	119	Benefit maximum for this time period or occurrence has been reached.	1/1/95	2/29/04	
OA	121	Indemnification adjustment.	1/1/95		
OA	122	Psychiatric reduction.	1/1/95		

CO	125	Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	1/1/95	6/30/06	
PR	126	Deductible -- Major Medical	2/28/97		
PR	127	Coinsurance -- Major Medical	2/28/97		
CO	128	Newborn's services are covered in the mother's Allowance.	2/28/97		
CR	129	Payment denied - Prior processing information appears incorrect.	2/28/97	2/28/01	
OA	130	Claim submission fee.	2/28/97	6/30/01	
OA	131	Claim specific negotiated discount.	2/28/97		
OA	132	Prearranged demonstration project adjustment.	2/28/97		
OA	133	The disposition of this claim/service is pending further review.	2/28/97	10/31/99	
OA	134	Technical fees removed from charges.	10/31/98		
CO	135	Claim denied. Interim bills cannot be processed.	10/31/98		
OA	136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA).	10/31/98	10/31/06	
OA	137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	2/28/99		
CO	138	Claim/service denied. Appeal procedures not followed or time limits not met.	6/30/99		
CO	139	Contracted funding agreement - Subscriber is employed by the provider of services.	6/30/99		
PR	140	Patient/Insured health identification number and name do not match.	6/30/99		
OA	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	6/30/99	6/30/00	
CR	142	Claim adjusted by the monthly Medicaid patient liability amount.	6/30/00		
OA	143	Portion of payment deferred.	2/28/01		
CR	144	Incentive adjustment, e.g. preferred product/service.	6/30/01		
PI	145	Premium payment withholding	6/30/02		
CO	146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	6/30/02		
OA	147	Provider contracted/negotiated rate expired or not on file.	6/30/02		
OA	148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	6/30/02		
PR	149	Lifetime benefit maximum has been reached for this service/benefit category.	10/31/02		
PI	150	Payment adjusted because the payer deems the information submitted does not support this level of service.	10/31/02		
PI	151	Payment adjusted because the payer deems the information submitted does not support this many services.	10/31/02		
PI	152	Payment adjusted because the payer deems the information submitted does not support this length of service.	10/31/02		
PI	153	Payment adjusted because the payer deems the information submitted does not support this dosage.	10/31/02		
PI	154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	10/31/02		
OA	155	This claim is denied because the patient refused the service/procedure.	6/30/03		
OA	156	Flexible spending account payments	9/30/03		
CO	157	Payment denied/reduced because service/procedure was provided as a result of an act of war.	9/30/03		
CO	158	Payment denied/reduced because the service/procedure was provided outside of the United States.	9/30/03		
CO	159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.	9/30/03		
CO	160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	9/30/03		
OA	161	Provider performance bonus	2/29/04		
CO	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	2/29/04		
CR	163	Claim/Service adjusted because the attachment referenced on the claim was not received.	6/30/04		
CR	164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	6/30/04		
CO	165	Payment denied /reduced for absence of, or exceeded referral	10/31/04		
PR	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	2/28/05		
CO	167	This (these) diagnosis(es) is (are) not covered.	6/30/05		
PR	168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan	6/30/05		
PI	169	Payment adjusted because an alternate benefit has been provided	6/30/05		
CO	170	Payment is denied when performed/billed by this type of provider.	6/30/05		

CO	171	Payment is denied when performed/billed by this type of provider in this type of facility.	6/30/05		
CO	172	Payment is adjusted when performed/billed by a provider of this specialty	6/30/05		
CR	173	Payment adjusted because this service was not prescribed by a physician	6/30/05		
CO	174	Payment denied because this service was not prescribed prior to delivery	6/30/05		
CO	175	Payment denied because the prescription is incomplete	6/30/05		
CO	176	Payment denied because the prescription is not current	6/30/05		
PR	177	Payment denied because the patient has not met the required eligibility requirements	6/30/05		
CR	178	Payment adjusted because the patient has not met the required spend down requirements.	6/30/05		
CR	179	Payment adjusted because the patient has not met the required waiting requirements	6/30/05		
CR	180	Payment adjusted because the patient has not met the required residency requirements	6/30/05		
CR	181	Payment adjusted because this procedure code was invalid on the date of service	6/30/05		
CR	182	Payment adjusted because the procedure modifier was invalid on the date of service	6/30/05	8/8/05	
CO	183	The referring provider is not eligible to refer the service billed.	6/30/05		
CO	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	6/30/05		
CO	185	The rendering provider is not eligible to perform the service billed.	6/30/05		
OA	186	Payment adjusted since the level of care changed	6/30/05		
OA	187	Health Savings account payments	6/30/05		
CO	188	This product/procedure is only covered when used according to FDA recommendations.	6/30/05		
OA	189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	6/30/05		
CO	190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	10/31/05		
CO	191	carrier.	10/31/05		
OA	192	Non standard adjustment code from paper remittance advice.	10/31/05		
CO	193	Original payment decision is being maintained. This claim was processed properly the first time.	2/28/06		
PI	194	physician	2/28/06		
PI	195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	2/28/06		
PI	197	Payment adjusted for absence of precertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	10/31/06	7/9/07	
PI	198	Payment Adjusted for exceeding precertification/ authorization.	10/31/06		
OA	199	Revenue code and Procedure code do not match.	10/31/06		
PR	200	Expenses incurred during lapse in coverage	10/31/06		
PR	201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC “Medicare set aside arrangement” or other agreement. (Use group code PR).	10/31/06		
PI	202	Payment adjusted due to non-covered personal comfort or convenience services.	2/28/07		
PI	203	Payment adjusted for discontinued or reduced service.	2/28/07		
PR	204	This service/equipment/drug is not covered under the patient’s current benefit plan	2/28/07		
CO	205	Pharmacy discount card processing fee	7/9/07		
OA	206	NPI denial - missing	7/9/07		
OA	207	NPI denial - Invalid format	7/9/07		5/23/08
OA	208	NPI denial - not matched	7/9/07		
OA	209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	7/9/07		
PI	210	Payment adjusted because pre-certification/authorization not received in a timely fashion	7/9/07		
CO	211	National Drug Codes (NDC) not eligible for rebate, are not covered.	7/9/07		
PI	A0	Patient refund amount.	1/1/95		
OA	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	1/1/95	10/31/06	
CO	A2	Contractual adjustment.	1/1/95	2/28/07	1/1/08
CO	A4	Medicare Claim PPS Capital Day Outlier Amount.	1/1/95		
CO	A5	Medicare Claim PPS Capital Cost Outlier Amount.	1/1/95		

OA	**A6**	Prior hospitalization or 30 day transfer requirement not met.	**1/1/95**		
PI	**A7**	Presumptive Payment Adjustment	**1/1/95**		
OA	**A8**	Claim denied; ungroupable DRG	**1/1/95**		
PR	**B1**	Non-covered visits.	**1/1/95**		
CO	**B10**	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	**1/1/95**		
OA	**B11**	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	**1/1/95**		
OA	**B12**	Services not documented in patients' medical records.	**1/1/95**		
OA	**B13**	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**1/1/95**		
CO	**B14**	Payment denied because only one visit or consultation per physician per day is covered.	**1/1/95**	**2/28/01**	
OA	**B15**	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	**1/1/95**	**10/31/06**	
CO	**B16**	Payment adjusted because `New Patient' qualifications were not met.	**1/1/95**	**2/28/01**	
OA	**B18**	Payment adjusted because this procedure code and modifier were invalid on the date of service	**1/1/95**	**6/30/05**	
OA	**B20**	Payment adjusted because procedure/service was partially or fully furnished by another provider.	**1/1/95**	**2/28/01**	
OA	**B22**	This payment is adjusted based on the diagnosis.	**1/1/95**	**2/28/01**	
CO	**B23**	Payment denied because this provider has failed an aspect of a proficiency testing program.	**1/1/95**	**2/28/01**	
CO	**B4**	Late filing penalty.	**1/1/95**		
CO	**B5**	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**1/1/95**	**2/28/01**	
CO	**B7**	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**1/1/95**	**10/31/98**	
CR	**B8**	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	**1/1/95**		
PR	**B9**	Services not covered because the patient is enrolled in a Hospice.	**1/1/95**		
PI	**W1**	Workers Compensation State Fee Schedule Adjustment	**2/29/00**		